

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County WicomicoVillage or City Salisbury(No. P 4 HospitalCamden DistSt.; 13

Ward)

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Howard Austin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Divorced
(Write the word)6 DATE OF BIRTH no record as near as we know 1848
(Month) (Day) (Year)7 AGE 67 yrs. - mos. - ds. If LESS than 1 day, - hrs. OR - min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Printer

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Del

PARENTS

10 NAME OF FATHER no not know11 BIRTHPLACE OF FATHER (State or country) " "12 MAIDEN NAME OF MOTHER " "13 BIRTHPLACE OF MOTHER (State or country) " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H E Hordesty(Address) Bridgville Del

15

Filed July 16, 1915S. May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 3, 1915 to July 15, 1915that I last saw him alive on July 15, 1915and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH * was as follows:

Chronic interstitial
neuropathicContributory Secondary Chronic interstitial
neuropathic(Signed) J. M. O.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 15 yrs. 15 mos. 15 ds. In the State, 15 yrs. 15 mos. 15 ds.Where was disease contracted, Frederic DelIf not at place of death? Frederic DelFormer or usual residence Frederic Del

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bridgville DelJuly 16, 1915

20 UNDERTAKER

ADDRESS

Holloway & CoSalisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 5 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wilcombe

Village or City

Mar Salisbury(No. 104)Parsons St.St.; 5 Ward

STATE OF MARYLAND

CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elastic Barchley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

A.A.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Aug (Month) 17 (Day), 1914 (Year)

7 AGE

11 yrs. 14 mos. 14 ds. OR 1 day, 14 hrs. 14 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Nat. Army

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John Barchley

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Harriet Barchley

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Barchley

(Address)

Salisbury Md

15

Filed July 31, 1915 N. P. Turner

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 28, 1915 (Month) 31 (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 28, 1915, to July 31, 1915, that I last saw him alive on July 29, 1915.

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) 14 yrs. 14 mos. 14 ds.

Contributory

Secondary

(Duration) 14 yrs. 14 mos. 14 ds.

(Signed)

J. W. Roberts, M. D.
7-31, 1915 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 11 yrs. 13 mos. 13 ds. In the State 11 yrs. 13 mos. 13 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

Wisconsin

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Flowerhill Cemetery July 31, 1915

20 UNDERTAKER

ADDRESS

L. E. Stewart Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

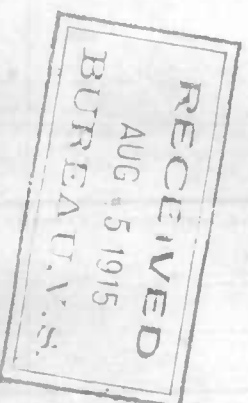
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 12090
County Wicomico

Village or City Parsonsburg

2 FULL NAME Anna Cecelia Brown

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 332

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH June 23rd, 1915 (Month) (Day) (Year)

7 AGE 2 yrs. 21 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Md.

10 NAME OF FATHER Chas. F. Brown

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Bickley

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. F. Brown M.D.

(Address) Parsonsburg Md.

15 Filed 7/14, 1915 A. Frank Tind

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1915, to July 14th, 1915,

that I last saw her alive on July 14th, 1915,

and that death occurred on the date stated above, at 10:55 p.m.

The CAUSE OF DEATH* was as follows:

Ileocolitis

(Duration) yrs. mos. 12 ds.

Contributory Gastro enteritis

(Duration) yrs. mos. 21 ds.

(Signed) Charles F. Brown, M.D.

July 14, 1915. (Address) Parsonsburg Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Md. July 16, 1915

20 UNDERTAKER ADDRESS

The Hill & Johnson Co Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 4 1915
BUREAU, V.S.

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1 PLACE OF DEATH McCombs
County McCombs

12091

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City Wittenburg, Ind. (No. Trappe Dist St. 7 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME No name Brumby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 19, 1915
(Month) (Day) (Year)

7 AGE 6 mos. fetus If LESS than 1 day.....hrs. OR.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Wittenburg, Ind

PARENTS
10 NAME OF FATHER Mr Earl Brumby
11 BIRTHPLACE OF FATHER (State or country) McCombs Co. Ind
12 MAIDEN NAME OF MOTHER Nettie May Glasgow
13 BIRTHPLACE OF MOTHER (State or country) McCombs Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Earl Brumby

(Address) Wittenburg, Ind

15 Filed July 19, 1915 N P Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1915 to July 19, 1915
that I last saw him alive on July 19, 1915

and that death occurred on the date stated above, at Wittenburg, Ind

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory unknown
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. C. Smith, M. D.
July 19, 1915 (Address) Salisbury, Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethland Cemetery DATE OF BURIAL July 20, 1915

20 UNDERTAKER Bry Brumby ADDRESS Wittenburg, Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

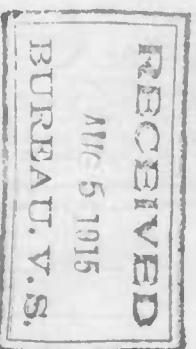
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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12092

1 PLACE OF DEATH

County WicomicoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury, Md. (No. Salisbury St.; 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Geneva Conway

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Afro American 5 SINGLE, MARRIED, WIDDED, OR DIVORCED. (Write the word)6 DATE OF BIRTH February 24th, 1915 (Month) (Day) (Year)7 AGE 4 yrs. 14 mos. 14 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Roland Dashiield11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Marie Conway13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Dashiield(Address) Salisbury, Md.15 Filed July 8th, 1915 N.P. Turner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5th 8th, 1915 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from 191 to July 8th, 1915that I last saw him alive on after death 191and that death occurred on the date stated above, at 12 PM

The CAUSE OF DEATH was as follows:

Hereditary SyphilisContributory (Duration) yrs. 3 mos. 22 ds.

Secondary

(Signed) J.W. Roberts M. O.July 8th, 1915 (Address) Salisbury, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. 22 ds. In the State, yrs. 3 mos. 22 ds.

Where was disease contracted, If not at place of death?

Former or usual residence Salisbury, Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Better field Salisbury, Md. July 8th, 1915

20 UNDERTAKER ADDRESS

Halloway & Co Salisbury

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto. Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state means or injury and qualify as *ACCIDENTAL*, *SUICIDAL*, or *HOMICIDAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 4 5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 12093

County WicomicoVillage or City Zaskin

(No. _____)

St.; _____ Ward)

2 FULL NAME

Sarah E. CanningSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Widow

6 DATE OF BIRTH

March 9

(Month)

(Day)

(Year)

7 AGE

73

yrs.

4

mos.

ds.

It LESS than
1 day, _____ hrs.
OR, _____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)At Home9 BIRTHPLACE
(State or country)Zaskin

PARENTS

10 NAME OF
FATHERHenry Larmore11 BIRTHPLACE
OF FATHER
(State or country)MD12 MAIDEN NAME
OF MOTHERSarah E. Larmore13 BIRTHPLACE
OF MOTHER
(State or country)MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Blum

(Address)

Zaskin MD

15

Filed

July 10th

1915

L. T. Walter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July9

(Month)

(Day)

(Year)

1915

17 I HEREBY CERTIFY, That I attended deceased from

July 2, 1915, to July 9, 1915,that I last saw her alive on July 9, 1915.and that death occurred on the date stated above, at 4:17 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes etiology (?)(Duration) _____ yrs. _____ mos. 12 ds.Contributory
SecondaryHemorrhage bowel(Duration) _____ yrs. _____ mos. 2 ds.

(Signed)

J. L. Warner, M. D.July 9, 1915 (Address) Wilmington, Del.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Zaskin ME CemeteryJuly 11, 1915

20 UNDERTAKER

ADDRESS

C. G. MurrishBivalve Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Micsonico (S) 12094
Village or City Sanctico (No. _____, St.; _____ Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 331

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Baby Crawford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 22, 1915
(Month) (Day) (Year)

7 AGE Ated Born If LESS than 1 day, ____ hrs. OR ____ min. ?
____ yrs. ____ mos. ____ ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Sanctico, Md.

PARENTS
10 NAME OF FATHER Guy S. Crawford
11 BIRTHPLACE OF FATHER (State or country) Sanctico, Md.
12 MAIDEN NAME OF MOTHER Agnes S. Crawford
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes S. Crawford
(Address) Sanctico, Md.

15 Filed _____, 191____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 22, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1915, to July 22, 1915, that I last saw h— alive on _____, 191____, and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Abortion about 3 mos
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Signed) J. D. Carpenter M. O.
July 22, 1915 (Address) Sanctico, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sanctico, Md. DATE OF BURIAL July 22, 1915

20 UNDERTAKER Sam Jones ADDRESS Sanctico, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

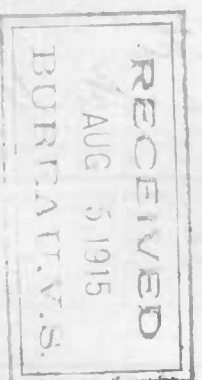
[Approved by U. S. Census and American Public Health Association.]

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gus, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of, (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STRUCK, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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12095

1 PLACE OF DEATH

County WicomicoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337Village or City Bivalve (No. 337)

St.; Ward

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Joshua T. Dashield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH

1888
(Month) (Day) (Year)

7 AGE

57

If LESS than

1 day, hrs.

yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.Farmer(b) General nature of industry,
business, or establishment in
which employed (or employer)own

9 BIRTHPLACE

(State or country)

Maryland10 NAME OF
FATHERdon't know

PARENTS

11 BIRTHPLACE
OF FATHER
(State or country)Don't know12 MAIDEN NAME
OF MOTHERPeggie Ann Bandy13 BIRTHPLACE
OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Preston Dashield

(Address)

Tonasket Md

15

Filed

July 16, 1915 529 Waller

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

1914, to 1915that I last saw him alive on May 2, 1915and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Drowning suicidal
(throwing him in well.)
(Fudith of summer July.)

(Duration) yrs. mos. ds.

Contributory
Secondary(Signed) R E Caldwell, M. D.July 14, 1915 (Address) Bivalve Md.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Tonasket Md Cemetery July 16, 1915

20 UNDERTAKER ADDRESS

C. G. Mersich Bivalve Md

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MARGIN RESERVED FOR BINDING

V. S. No. 1.

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

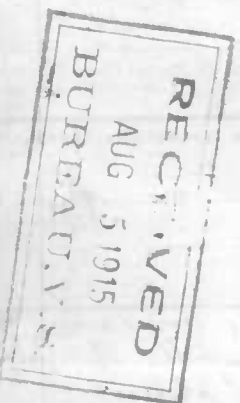
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH County <u>Wicomico</u> Village or City <u>Mardela Spg.</u> (No. <u>154</u>)		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>330</u>	
2 FULL NAME <u>Noah Dashiell</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>March 18th</u> , 18 <u>37</u> (Month) (Day) (Year)			
7 AGE <u>78</u> yrs. <u>3</u> mos. <u>13</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Isaac Dashiell</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>		
	12 MAIDEN NAME OF MOTHER <u>Dashiell</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. L. Maller</u> (Address) <u>Mardela</u>			
15 Filed _____, 191 <u>5</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>July 1st</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Old age & General debility</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Isaac L. English Regi</u> <u>July 1</u> , 191 <u>5</u> (Address) <u>Mardela</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>"Old Church" Cemetery</u>		DATE OF BURIAL <u>July 3</u> , 191 <u>5</u>	
20 UNDERTAKER <u>A. L. Deabrose</u>		ADDRESS <u>Mardela</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 6 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
County Princess Anne

12097

Village or City Salisbury (No. 5)

Parsons Dist.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333# 5 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Robert M. Doves

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH July 17, 1915
(Month) (Day) (Year)7 AGE 18 hours If LESS than 1 day, 8 hrs.
yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Salisbury, Md10 NAME OF FATHER Ernest E Doves11 BIRTHPLACE OF FATHER (State or country) Princess Anne Co. Md12 MAIDEN NAME OF MOTHER Lady Phillips13 BIRTHPLACE OF MOTHER (State or country) North Dakota

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest E Doves(Address) Salisbury, Md15 Filed July 17, 1915 May Turner
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 17, 1915 to July 17, 1915, that I last saw her alive on July 17, 1915and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pr premature birth

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Dr. McCarty, M. D.July 17, 1915 (Address) Salisbury, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2), whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parsons Beach, Salisbury, Md July 18th, 1915

20 UNDERTAKER ADDRESS

The Hill & Johnson Co Salisbury

JMD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fireman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—boat mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wicomico 12098STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337Village or City Bivalve (No. 587)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nellie C. Dunn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Sept 10, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 10 mos. 6 ds. OR 1 day. 10 hrs. min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Wid.

PARENTS
10 NAME OF FATHER Samuel L. Dunn
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Grace L. Jackson
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel L. Dunn
(Address) Bivalve

15 Filed July 17, 1915 B. L. T. Walter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1915, to July 15, 1915, that I last saw him alive on July 15, 1915, and that death occurred on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

Diarrhoea & enteritis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) R. E. Caswell M. D.
July 16, 1915 (Address) Bivalve Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

W. Cemetery Bivalve July 17, 1915
20 UNDERTAKER C. E. Weirich ADDRESS Bivalve Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 12099
County Wicomico

Village or City Near Hebron (No. _____, _____)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 338

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles W. Ennis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 5, 1915
(Month) (Day) (Year)

7 AGE 1 yrs. 10 mos. 10 ds. 1 day, 10 hrs. 10 min. ?
OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Wicomico

10 NAME OF FATHER Charles Ennis

11 BIRTHPLACE OF FATHER (State or country) Wicomico

12 MAIDEN NAME OF MOTHER Mary A. Moore

13 BIRTHPLACE OF MOTHER (State or country) Wicomico

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Intendant) Charles Ennis

(Address) Hebron Md

15 Filed July 26, 1915 H. S. Phillips
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____ to _____, 191____.

that I last saw him alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Bowel Trouble

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Conaway, M. D.
July 21, 1915 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Memorial Cemetery DATE OF BURIAL July 21, 1915

20 UNDERTAKER Lake Seabreeze ADDRESS Memorial Cemetery

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as *ACCIDENTAL*, *SUICIDAL*, or *HOMICIDAL*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 7 1915

BUREAU, U. S. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

12100

County

Wicomico

Village or City

Near Salisbury

(No.)

Camden St

Registration Dist. No.

333

St. 13th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mrs Martha E. Evans

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

November 5, 1865

7 AGE

49 yrs. 8 mos. 14 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Delaware

PARENTS

10 NAME OF FATHER

Joseph D. Baker

11 BIRTHPLACE OF FATHER

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Lavin E. Mitchell

13 BIRTHPLACE OF MOTHER

(State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Rhoda Ake

(Address)

Bridgetown, Del.

15

Filed

July 19, 1915

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 19, 1915

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1915, to July 19, 1915.

that I last saw her alive on July 18, 1915

and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis (Duration) 2 yrs. 10 mos. ds.

Contributory Secondary

Phthisis (Duration) 1 yrs. 10 mos. ds.

(Signed) Geo. H. Todd, M. D.

July 19, 1915 (Address) Salisbury Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. ds. In the most of life? State yrs. 0 mos. ds.

Where was disease contracted, about 1 year

If not at place of death? Former or usual residence Parsonsburg Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lumbago Hundred

7/20/15, 1915

20 UNDERTAKER

ADDRESS

The Will & Johnson Co Salisbury, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 5 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wicomico</u>		12101		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Tammittand</u> (No. <u>R D #2</u>)		Trafalgar St.		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>James W. Turbush</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widower</u> (Write the word)			
6 DATE OF BIRTH <u>No mat. Record</u> , 1839 (Month) (Day) (Year)					
7 AGE <u>76</u> yrs. <u>1</u> mos. <u>1</u> ds.		If LESS than 1 day... hrs. OR... min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>Washington Turbush</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Russell</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George B. Turbush</u> (Address) <u>Wetipquin Md</u>					
15 Filed <u>July 2</u> , 1915 <u>M. Turner</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July</u> , 1915 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>was called to view</u> , 1915, to <u>body</u> , that I last saw him alive on <u>July 1st</u> , 1915, and that death occurred on the date stated above, at <u>3:30 p.</u> The CAUSE OF DEATH * was as follows:					
<u>Cerebral Embolism</u> (Duration) yrs. mos. ds.					
Contributory <u>aortic disease</u> Secondary					
(Duration) yrs. mos. ds.					
(Signed) <u>Jo I. McLaughlin</u> , M. D. <u>July 2</u> , 1915 (Address) <u>Frederick Md.</u>					
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Trafalgar Md</u> DATE OF BURIAL <u>July 3</u> , 1915					
20 UNDERTAKER <u>C. H. Messick</u> ADDRESS <u>Birdsboro Md</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

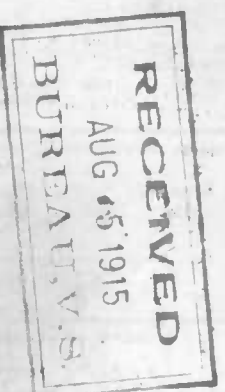
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer at Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers wife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *Note*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Wicomico

Village or City

Salisbury

(No.

Camden St. 13

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie Gale

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

African American

5 SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

no record

(Month)

(Day)

1895 (Year)

7 AGE

The best we could get 20 yrs.

If LESS than day hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

William Waters

11 BIRTHPLACE OF FATHER

Md

12 MAIDEN NAME OF MOTHER

Sadie Simons

13 BIRTHPLACE OF MOTHER

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kenya Gale

(Address)

Salisbury Md

15

Filed July 29 1915 V. S. Registrar

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

(Month)

29

(Day)

1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 15, 1915, to July 29, 1915,

that I last saw him alive on July 29, 1915,

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH was as follows:

Peritonitis

Contributory

Secondary

Gonorrheal pyosal-

pingitis

(Duration) yrs. mos. ds.

(Signed) J. S. M. O.

July 29, 1915 (Address) Salisbury Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, Litchfield Co. Md.

Where was disease contracted, Salisbury Md

if not at place of death?

Former or usual residence Salisbury Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Houston Cemetery July 30, 1915

20 UNDERTAKER

ADDRESS

Holloway & Co Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

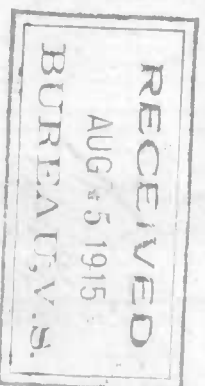
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 12103
County Wicomico

Village or City Near Hebron (No. Quantico Dist. St. 2 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 31

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nancy Catharine Gellis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH March 29, 1858
(Month) (Day) (Year)

7 AGE 57 yrs. 3 mos. 4 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Wicomico Co. Md.

10 NAME OF FATHER Cliff P. Bennett

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Jane Elliott

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. Agnes Lowe,

(Address) Mardela, Md.

15 Filed 9, 191

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to July 2, 1915, that I last saw her alive on July 2, 1915.

and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Gallstones on Liver.
Arteriosclerosis of
Arteries of Liver
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. C. Conway, M. D.
July 3, 1915 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, at home
If not at place of death?

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Mardela, Md. DATE OF BURIAL 7/4/15 3 P.M.
191

20 UNDERTAKER The Hill & Johnson Co. ADDRESS Salisbury, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

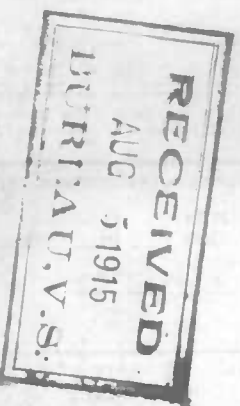
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

12104

County

Hundred

or
Village

City

No.

St.

Ward

STANDARD DEATH CERTIFICATE
DELAWARE

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If less than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

PARENTS

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

Filed

July 24, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH * was as follows:

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) P. J. Jaccard M. D.

(Address) Guilford, Conn.

* State the Disease Causing Death, or, in deaths from Violent Causes,
State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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(b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc.; without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus. *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

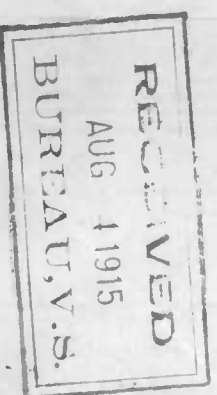
Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-

lapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *Septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATH state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tenans*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Certificates will be returned for additional information which give any of the following diseases without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hæmorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyæmia, septicæmia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

STATE BOARD OF HEALTH OF DELAWARE

APPROVED NOV. 11, 1909.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		12105		STATE OF MARYLAND	
County		Wicomico		CERTIFICATE OF DEATH	
Village or City		Salisbury		Registration Dist. No. 233	
		(No. 311)		Water St.; 5 Ward	
2 FULL NAME		Harvey L. Henry			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
Male	A.A.	married			
6 DATE OF BIRTH	about 1862				
		(Month) (Day) (Year)			
7 AGE	about 53		If LESS than 1 day, hrs. OR min. ?		
8 OCCUPATION		(a) Trade, profession, or particular kind of work			
		General Laborer			
		(b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country)		Maryland			
PARENTS	10 NAME OF FATHER	William Henry			
	11 BIRTHPLACE OF FATHER (State or country)	Maryland			
	12 MAIDEN NAME OF MOTHER	Clara A. Berry			
	13 BIRTHPLACE OF MOTHER (State or country)	Maryland			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant)		Clara Morris			
(Address)		408 Ellen St.			
15		Filed July 24, 1915			
		G. Gray Trimmer Deputy REGISTRAR			
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH		July 24, 1915			
		(Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from July 11, 1915 to July 24, 1915					
that I last saw him alive on July 22, 1915					
and that death occurred on the date stated above, at 11 A. M.					
The CAUSE OF DEATH* was as follows:					
Aortic Regurgitation					
(Duration) yrs. mos. ds.					
Contributory Exposure & fractured ribs					
Secondary overexhaust.					
(Duration) yrs. mos. ds.					
(Signed) J. D. Stewart, M. D.					
July 24, 1915 (Address) Salisbury, Md.					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place of death		53 yrs. mos. ds.		to the State 53 yrs. mos. ds.	
Where was disease contracted, If not at place of death?					
Former or usual residence Salisbury, Md.					
19 PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL			
Houston Cemetery, Salisbury		July 26, 1915			
20 UNDERTAKER		ADDRESS			
Jas. F. Stewart		Salisbury, Md.			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 15 1915

BUREAU V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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12106

150

1 PLACE OF DEATH
County Maryland Camden Dist.

Registration Dist. No. 333

Village or City Salisbury (No. 13 Ward) [It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)

6 DATE OF BIRTH July 9, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 1 ds. OR _____ min. ?
It LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Salisbury, Md.

PARENTS

10 NAME OF FATHER Archie B. Still

11 BIRTHPLACE OF FATHER (State or country) Delmar

12 MAIDEN NAME OF MOTHER Bessie J. Still

13 BIRTHPLACE OF MOTHER (State or country) Delmar.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Polto
(Address) Salisbury Md

15 Filed July 11, 1915 by W. P. Garner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 10, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1915 to July 10, 1915
that I last saw him alive on July 10, 1915
and that death occurred on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Thomas P. Pugh, M. D.
July 11, 1915 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Salisbury Md DATE OF BURIAL July 11, 1915
Stons burial ground

20 UNDERTAKER Carl Polto ADDRESS Salisbury Md
acting as undertaker

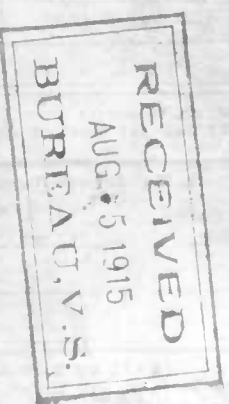
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thena," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 12107		STATE OF MARYLAND	
County Wicomico		CERTIFICATE OF DEATH	
Village or City Tyaskin (No. 14)		Registration Dist. No. 37X337	
2 FULL NAME James E. B. Horner		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married	
6 DATE OF BIRTH Nov 15, 1846 (Month) (Day) (Year)			
7 AGE 68 yrs. 8 mos. 15 ds.		If LESS than 1 day, ... hrs. OR ... min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work Harmer (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) Maryland			
PARENTS	10 NAME OF FATHER L. K. Horner		
	11 BIRTHPLACE OF FATHER (State or country) Maryland		
	12 MAIDEN NAME OF MOTHER Lucinda J. J. J.		
13 BIRTHPLACE OF MOTHER (State or country) Maryland			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Reese Horner (Address) Tyaskin Md.			
15 Filed 191 REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH July 31, 1915 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from July 23, 1915 to July 30, 1915 that I last saw him alive on July 30, 1915 and that death occurred on the date stated above, at 9 a. m. The CAUSE OF DEATH* was as follows: Bacillary Dysentery (Duration) ... yrs. ... mos. ... ds. 8 Contributory (Secondary) General debility (Duration) ... yrs. ... mos. ... ds. 1 (Signed) J. D. LaPorte M. D. July 31, 1915 (Address) Seawater, Md.			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL Tyaskin M. E. Cemetery		DATE OF BURIAL Aug 2nd, 1915	
20 UNDERTAKER W. H. Messick		ADDRESS Seawater, Md.	

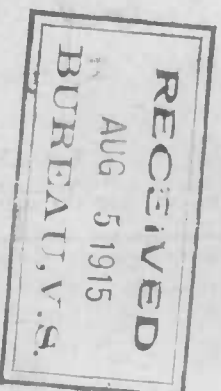
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary). 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 12108
County Wicomico
Village or City Quantico (No. 154)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 33

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Calib Jackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWER, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH Unknown but about 1824
(Month) (Day) (Year)

7 AGE about 81 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Old Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Liton Jackson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Zephora Goble

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maggie Stays

(Address) Quantico Md

15 Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 14, 1915 to July 4, 1915
that I last saw him alive on July 4, 1915

and that death occurred on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

General Decline

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Carlini, M. D.
7/4, 1915 (Address) Quantico Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Quantico Md DATE OF BURIAL July 6, 1915

20 UNDERTAKER J. H. Stewart ADDRESS Adelphi

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Cardi-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

12109

County

Wicomico

Village or City

Willards

(No.)

St.;

Ward)

Registration Dist. No.

332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James German

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

July

9

1831

(Month)

(Day)

(Year)

7 AGE

84

yrs.

5

mos.

ds.

OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

William German

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Clarissa Baker

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laurie's Baker

(Address)

Willards Md

15

Filed

July 10, 1915

J. Frank Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

(Month)

(Day)

1915 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1915, to

1915

that I last saw him

alive on

1915

and that death occurred on the date stated above at

m.

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. Frank Smith

July 10, 1915

(Address) Fittsville, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Hope Md

July 10, 1915

20 UNDERTAKER

ADDRESS

J. Ratliff

Farlow Willards Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puereral septicæmia," "Puereral peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 14 1915

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

12110

County

McMinn

Village or City

Parsonsbury (No.

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Eloise Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

(Month) (Day) (Year)

7 AGE

about 84 yrs. mos. ds. OR min. ?

If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

General laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

McMinn Co

PARENTS

10 NAME OF FATHER

John White

11 BIRTHPLACE OF FATHER

(State or country)

McMinn

12 MAIDEN NAME OF MOTHER

Sarah Barker

13 BIRTHPLACE OF MOTHER

(State or country)

McMinn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Lane

(Address)

Bilston Lane

15

Filed

7/17

1915

J. H. B. Smith

Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 17th, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 12, 1915, to July 12, 1915.

that I last saw him alive on July 12, 1915.

and that death occurred on the date stated above, at 9-30 P.M.

The CAUSE OF DEATH was as follows:

Dysentery

Contributory Secondary

(Duration)

yrs.

mos.

ds.

Severe Debility

(Signed)

Chas. F. Brown, M. D.

(Duration)

yrs.

mos.

ds.

July 22, 1915 (Address) Parsonsbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bishop's Chapel

7/19, 1915

20 UNDERTAKER

ADDRESS

Wm. P. Parsons

Whitesville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 4 1915
BUREAU U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Wicomico

12111

189

Village or City

Powellsville

(No.)

St.

Ward)

Registration Dist. No.

332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Archibald Hargis Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed (Write the word)

6 DATE OF BIRTH

July 6, 1837
(Month) (Day) (Year)

7 AGE

78 yrs. 9 mos. 9 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9 BIRTHPLACE

(State or country)

Wicomico Md

PARENTS

10 NAME OF FATHER

John F Jones

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary B Brittingham

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laura E Jones

(Address)

Willards Md

15

Filed

July 15, 191

J. H. Hargis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7 / 15, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. H. Hargis, Deft. D.

July 15, 1915 (Address) Willards, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
It not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt. Pleasant Cemetery 7 / 15, 1915

20 UNDERTAKER

ADDRESS

G. Rathbun Harlow Willards Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meclesles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Meclesles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Coma-frenia"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tramtion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 14 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

12112

County WicomicoVillage or City New Hope (No. _____, St.; _____ Ward)

2 FULL NAME

Mary Gertrude JonesSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 2, 1915
(Month) (Day) (Year)

7 AGE 1 yrs. 19 mos. 19 ds. If LESS than 1 day, _____ hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Maryland

PARENTS

10 NAME OF FATHER Elmer Jones

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Duncan

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Jones(Address) Willard's Inn

15 Filed July 2, 1915 W. L. Parsons
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1915, to July 2, 1915, that I last saw her alive on July 15, 1915, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows:

Starvation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Heart lip + cleft palate

Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. A. Holland, M. D.July 2, 1915 (Address) Whaleyville Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New HopeJuly 3, 1915

20 UNDERTAKER

ADDRESS

W. L. Parsons

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

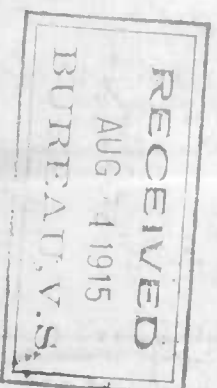
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonium, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranquil," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Breacher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telumus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

121113

County

Wicomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

338

Village or City

Spring Hill

(No.)

Hebron Dist.

#

St.; 14 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sarah E. Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

ORDIVORCED,

(Write the word)

Widow

6 DATE OF BIRTH

Unknown

7 AGE

About 68

yrs.

mos.

ds.

11 LESS than

1 day.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

John Ennis

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

I don't know

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles E. Jones

(Address)

Salisbury Md. Route 2

15

Filed

July 11, 1915 H. S. Philip

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

10

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 13

1915

to June 3

1915

that I last saw her alive on

June 3

1915

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis
Found dead in bed

(Duration).....yrs.....mos.....ds.

Contributory
Secondary

(Duration).....yrs.....mos.....ds.

(Signed)

H. C. Conway

M. D.

July 10, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

8

mos.

10

ds.

In the

65

yrs.

—

mos.

—

ds.

Where was disease contracted,

If not at place of death?

no

Former or

usual residence

near Whiton Worcester Co

19 PLACE OF BURIAL OR REMOVAL

20 DATE OF BURIAL

The Jones burying ground near Whiton

July 11, 1915

20 UNDERTAKER

Worcester Co.

ADDRESS

The Hill & Johnson Co. Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

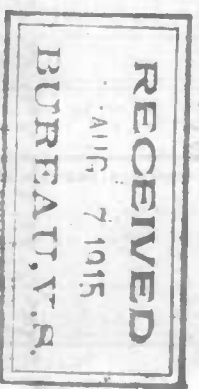
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital"), "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Wisconsin</u> 12114			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Allen</u> (No. <u>Trappe Dist.</u> St.; <u>7</u> Ward)			Registration Dist. No. <u>323</u>		
2 FULL NAME <u>Phyllis Marie Kellow</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Apr 22, 1915</u> (Month) (Day) (Year)					
7 AGE yrs. <u>2</u> mos. <u>18</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>md.</u>					
PARENTS					
10 NAME OF FATHER <u>James Kellow</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>md.</u>					
12 MAIDEN NAME OF MOTHER <u>Maggie Johnson</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Kellow</u> (Address) <u>Allen Md.</u>					
15 Filed <u>July 11, 1915</u> <u>May Turner</u> <u>Deputy</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 10, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Called to see her</u> to <u>July 10</u> , 1915, that I last saw her alive on <u>July 10</u> , 1915, and that death occurred on the date stated above, at <u>39</u> m. The CAUSE OF DEATH * was as follows: <u>Broncho-Pneumonia</u> (Duration) <u>about</u> yrs. <u>10</u> mos. <u>10</u> ds.					
Contributory Secondary					
(Signed) <u>Jos. L. McLaughlin</u> , M. D. <u>July 11, 1915</u> (Address) <u>Trappe Md.</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Allen</u> DATE OF BURIAL <u>July 11, 1915</u>					
20 UNDERTAKER <u>Stolman & Co</u> ADDRESS <u>Salisbury Md.</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

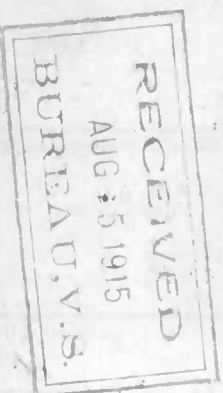
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plowman, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Tender," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia"); unqualified, is indefinite); *Tuberculosis of lungs, meningis,*

gcs, peritonaeum, etc., Carcinoma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Railway wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Wicomico

Camden Dist.

Village or City

Salisbury

(No.

Peninsula General Hospital St.; 13 Ward)

Registration Dist. No.

333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Zankford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

April 1st, 1867

7 AGE

48 yrs. 3 mos. 6 ds.

If LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)Night Watchman in
of Seaford Del

9 BIRTHPLACE

(State or country)

Delaware

10 NAME OF FATHER

John Zankford

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emmie Moore

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. L. Watson

(Address)

Seaford Del.

15

Filed

July 7th, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 7, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 5, 1915, to July 7, 1915,
that I last saw him alive on July 6, 1915

and that death occurred on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Gun shot (fatal) wound of abdomen,
piercing stomach (2 holes) Gall bladder
(2 holes) and liver.

Homicidal (Duration) yrs. mos. ds.

Contributory

Secondary

Peritonitis

(Duration) yrs. mos. 2 ds.

(Signed)

D. B. Potts

M. D.

July 7, 1915 (Address) Seaford Del.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 2 ds. to the State

Where was disease contracted, Seaford Del.

If not at place of death? Former or usual residence Seaford Del.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Seaford Del. July 9, 1915

20 UNDERTAKER

ADDRESS

M. L. Watson Seaford Del.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as, *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 15 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 12116
County Wicomico

Village or City Wetzel (No. 104)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 331

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Shamuel C. Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 2nd, 1915
(Month) (Day) (Year)

7 AGE 3 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Shamuel C. Mitchell

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Larnore

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James C. Mitchell

(Address) White Haven

15 Filed July 26, 1915 Lucy J. Walter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1915 to July 24th, 1915, that I last saw him alive on July 24, 1915

and that death occurred on the date stated above, at 5-2 a.m.

The CAUSE OF DEATH* was as follows:

Cholera dysenteriae

(Duration) yrs. mos. 4 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) R. E. Caldwell, M. D.

July 26, 1915 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wash. M.E. Cemetery DATE OF BURIAL July 26, 1915

20 UNDERTAKER C. G. Messick ADDRESS Baltimore

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Wicomico

Village or City

Netipquin (No. *104*)

St.; Ward)

STATE OF MARYLAND

CERTIFICATE OF DEATH

Registration Dist. No.

337

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James Frederick Moore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

colored

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

May 6th(Month) (Day) (Year) *1915*

7 AGE

yrs. *2* mos. *6* ds. OR min. ?

If LESS than 1 day.....hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Nathan H Moore

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Maggie Johnson

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant)

Maggie C Moore

(Address)

Netipquin Md

15

Filed

July 12, 1915 L. H. Walters

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 12, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*July 11th, 1915, to July 11th, 1915*that I last saw ~~him~~ *her* alive on *July 11*, 1915and that death occurred on the date stated above, at *3:30* m.

The CAUSE OF DEATH* was as follows:

Dysentery(Duration) yrs. mos. *3* ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

J. H. O'Day, M. D.*7-12*, 1915 (Address) *Netipquin*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Netipquin Md & County *July 13, 1915*

20 UNDERTAKER

ADDRESS

C. S. Mission *Bivabe Md*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

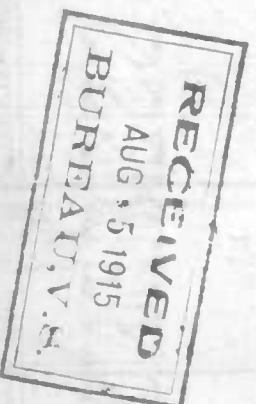
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberclelets of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Neomica

(S)

12118

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 233

Village or City Salisbury (No. Camden Dist. St.; 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant (Parker)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) —

6 DATE OF BIRTH July 25, 1915
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS
10 NAME OF FATHER Harley B Parker
11 BIRTHPLACE OF FATHER (State or country) Md
12 MAIDEN NAME OF MOTHER Bertma Insley
13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy E. Lewis
(Address) Salisbury Md

15 Filed July 28, 1915 3:30 May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mon Wed July 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mon Wed July 25, 1915, to —, 1915.

that I last saw him alive on —, 1915.

and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH * was as follows:

Born and

Contributory
Secondary

(Signed) N. D. Ward (Duration) — yrs. — mos. — ds.

July 26, 1915 (Address) Salisbury Md
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State, — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Dixons Cemetery DATE OF BURIAL July 26, 1915

20 UNDERTAKER Holloway & Co ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis,*

peritonaeum, etc., *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trama," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Retcher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 15 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Wesley Camden Dist. STATE OF MARYLAND
 County Wesley Camden Dist. CERTIFICATE OF DEATH
 Village or City Salisbury (No. 13 St.; 13 Ward) Registration Dist. No. 333
 2 FULL NAME John Parker [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH July 11, 1915
 (Month) (Day) (Year)
 7 AGE 4 mos John If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

July 11, 1915; May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1915, to July 11, 1915,
 that I last saw him alive on July 11, 1915.

and that death occurred on the date stated above, at 11:30 a.m.
 The CAUSE OF DEATH* was as follows:

Contributory Secondary

(Signed)

John Eldridge, M. D.
Salisbury, Md. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 6 mos yrs. mos. ds. In the State 2 yrs. mos. ds.

Where was disease contracted,
 If not at place of death?

Former or
 usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Deceased of City Hospital
Deputy REGISTRAR

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 25 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Wicomico

Village or City

W. Pomellenville

(No.)

St.;

Ward)

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John G. Perdue

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE, MARRIED, WIDDED OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

1827
(Month) (Day) (Year)

7 AGE

88

yrs.

mos.

ds.

If LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

Perdue

11 BIRTHPLACE OF FATHER

This record filed in lieu

12 MAIDEN NAME OF MOTHER

of original specimen

13 BIRTHPLACE OF MOTHER

by physician in

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

attendant. S22

(Address)

care of Rague - 1916

15

Filed

, 191

Trud L. J. Bower

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 15, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory
Secondary(Signed) L. H. Collins, M. D., 191 (Address) Pittsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

When was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery July 17, 1915

20 UNDERTAKER

ADDRESS

L. J. Payne Pomellenville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

12120

County

Wicomico

Village or City

Hebron

(No.

104

St.; Ward)

Registration Dist. No.

838

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Pettie Peters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

A.A.

5 SINGLE, ☒ YES
MARRIED, ☐
WIDDED, ☐
OR DIVORCED, ☐
(Write the word)

6 DATE OF BIRTH

Jan 20, 1915

7 AGE

6 yrs. 6 mos. 6 ds. OR 1 day, hrs. min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Nursing baby

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Christopher C. Peters

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary H. Braden

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Christopher C. Peters

(Address)

Hebron Md

15

Filed

July 26, 1915

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 26, 1915

17

I HEREBY CERTIFY, That I attended deceased from

July 25, 1915, to July 26, 1915, that I last saw her alive on July 26, 1915

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. C. Comanay, M. D.

July 26, 1915 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rachawalkin July 27, 1915

20 UNDERTAKER

ADDRESS

J. H. Stewart Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (v) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercle* of *lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fertal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Wicomico

Village or City

Mardela

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Emma Phillips

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 10, 1852

7 AGE

63 yrs. 3 mos. 19 ds.

If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Wicomico Co

10 NAME OF FATHER

Levin Phillips

11 BIRTHPLACE OF FATHER (State or country)

Wicomico Co

12 MAIDEN NAME OF MOTHER

Mary Gunby

13 BIRTHPLACE OF MOTHER (State or country)

Wicomico Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester A. Phillips

(Address)

Mardela Springs

15

Filed, 191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

330

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 29, 1915

17

I HEREBY CERTIFY, That I attended deceased from

March 16, 1915, to July 29, 1915.

that I last saw her alive on July 29, 1915.

and that death occurred on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bowell Tuberculosis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

H. B. Conaway

M. D.

July 30, 1915 (Address) H. Brown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mardela, Md

DATE OF BURIAL

8/1/15, 191

20 UNDERTAKER

The Hick Johnson Co.

ADDRESS

Salisbury, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH 2122
County Wicomico

Village or City Salisbury

(No. Trappe Dist.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. 7 Ward

² FULL NAME Wilbur Louis Puzey

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

⁶ DATE OF BIRTH May 26th, 1913
(Month) (Day) (Year)

⁷ AGE 2 yrs 2 mos 2 ds. OR 1 day 1 hrs. 1 min.
It LESS than

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Wicomico Co. Md.

PARENTS
¹⁰ NAME OF FATHER Lee Puzey
¹¹ BIRTHPLACE OF FATHER (State or country) Maryland
¹² MAIDEN NAME OF MOTHER Ella Smith
¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest F. Disharoon
(Address) Eden Md.

¹⁵ Filed July 28, 1915 V. P. Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH July 28, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from July 25, 1915, to July 28, 1915.

that I last saw him alive on July 27, 1915.

and that death occurred on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration) 3 yrs. 3 mos. 3 ds.

Contributory
Secondary

(Signed) M. B. Surges, M. D.
July 28, 1915 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted,
If not at place of death?
Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL Mountland M. E. Churchyard DATE OF BURIAL July 29th, 1915
²⁰ UNDERTAKER The Hill & Johnson Co. Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fireman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>12123</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Wicomico</u>		Registration Dist. No. <u>338</u>	
Village or City <u>Sharptown</u> (No. <u> </u>)		St.; <u> </u> Ward)	
2 FULL NAME <u>Helen M. Robinson</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>Sept 15, 1891</u> (Month) (Day) (Year)			
7 AGE <u>24</u> yrs. <u>10</u> mos. <u>29</u> ds.		If LESS than 1 day, <u> </u> hrs. OR <u> </u> min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>clerk in shoe store.</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Sharptown</u>			
PARENTS	10 NAME OF FATHER <u>James Robinson</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Sharptown</u>		
	12 MAIDEN NAME OF MOTHER <u>Laura Elzey</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Sharptown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Laura Robinson</u> (Address) <u>Sharptown</u>			
15 Filed <u>Aug 14</u> , 191 <u>5</u> <u>Roman</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
6 DATE OF DEATH <u>July 14</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 1</u> , 191 <u>5</u> to <u>July 14</u> , 191 <u>5</u> .			
that I last saw her alive on <u>July 14</u> , 191 <u>5</u> .			
and that death occurred on the date stated above, at <u>2 P.</u> m.			
The CAUSE OF DEATH* was as follows: <u>Tuberculosis of lungs</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u> </u> ds.			
Contributory Secondary (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.			
(Signed) <u>C. E. James</u> , M. D. <u>Apr 15, 1915</u> (Address) <u>Sharptown Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence:			
19 PLACE OF BURIAL OR REMOVAL <u>Sharptown</u>		DATE OF BURIAL <u>July 16, 1915</u>	
20 UNDERTAKER <u>W. H. Graves & Son</u>		ADDRESS <u>Sharptown</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 12124

County

Wicomico

Village or City

New Allen

(No.)

Trappe Dist.

Registration Dist. No.

223

St. #4

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bradford Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Here, not get the record

7 AGE

About

1 yrs. 11 mos. 0 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Wicomico Co. Md.

PARENTS

10 NAME OF FATHER

Charles Smith

11 BIRTHPLACE OF FATHER (State or country)

Wicomico Co. Md.

12 MAIDEN NAME OF MOTHER

Lda May Elliott

13 BIRTHPLACE OF MOTHER (State or country)

Wicomico Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Elliott

(Address)

Salisbury Md. Route 1

15

Filed

July 8, 1915

S. May Turner Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 5, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 29, 1915 to July 5, 1915 that I last saw him alive on July 5, 1915

and that death occurred on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 7 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Jos. L. McLaughlin, M. D.

July 6, 1915 (Address) Franklin D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; And (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salisbury

July 6th, 1915

20 UNDERTAKER

ADDRESS

The Hill & Johnson Co. Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

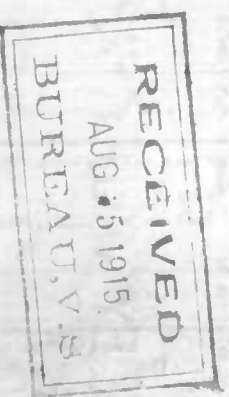
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not finally employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

12125

County WicomicoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 933Village or City New Salisbury (No. Salisbury Dist. 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME W. S. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH July 21, 1915
(Month) (Day) (Year)

7 AGE Still Born If LESS than 1 day.....hrs. yrs.....mos.....ds. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed July 21, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1915, to July 21, 1915, that I last saw him dead found July 21, 1915, and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

This was a 5 month child. dead at birth had been dead 2 or 3 days in utero
(Duration) yrs. mos. ds.

Contributory Secondary

(Signed) C. R. Smith, M. D.
July 21, 1915 (Address) Salisbury, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

In lot back of house July 21, 1915

20 UNDERTAKER

ADDRESS

Walter Taylor Fath RD 5 Salisbury, Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED
AUG - 5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 12126
County Wicomico

Village or City Salisbury

(No. _____)

Camden Dist

Registration Dist. No. 333

St.; 13th Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine Elizabeth Timmons

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH

Jan. 16, 1913
(Month) (Day) (Year)

7 AGE

2 yrs. 6 mos. 5 ds. 1 LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Mias E. Timmons

11 BIRTHPLACE OF FATHER

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Rosie Ellen Gray

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mias E. Timmons

(Address)

Salisbury, Md.

15

Filed July 23, 1915 N. P. Turner
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from July 21, 1915 to July 21, 1915

that I last saw her alive on July 21, 1915

and that death occurred on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Embolism caused by early mild chills

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) N. P. Wark, M. D.

July 22, 1915 (Address) Salisbury, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salisbury, Md. 7/23/15, 1915

20 UNDERTAKER

ADDRESS

The Hill Johnson Co. Salisbury, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

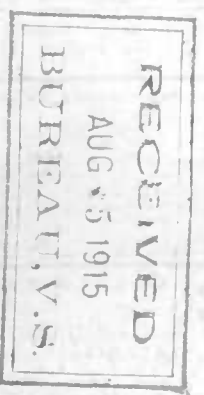
[Approved by U. S. Census and American Public Health Association.]

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY; WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Wicomico</u>		12127		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Salisbury</u> (No. <u>R D #5</u>)		105		Registration Dist. No. <u>33</u>	
2 FULL NAME <u>Annie R Trader</u>		St. <u>2</u> Ward		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Afro American</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>Sept 4, 1912</u> (Month) (Day) (Year)		7 AGE <u>2</u> yrs. <u>10</u> mos. <u>17</u> ds. If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>N. C.</u>					
PARENTS	10 NAME OF FATHER <u>John W Trader</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Cora Howe</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>N. C.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Cora Trader</u> (Address) <u>Salisbury Md R D #5</u>					
15 Filed <u>191</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 24, 1918</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 21, 1918</u> , to <u>July 21, 1918</u> , that I last saw her alive on <u>July 21, 1918</u> , and that death occurred on the date stated above, at <u>4:00</u> m. The CAUSE OF DEATH * was as follows: <u>Gastric Encephalitis</u>					
Contributory Secondary (Duration) yrs. mos. ds. <u>></u>					
(Signed) <u>N. D. Ward</u> , M. D. <u>July 21, 1918</u> (Address) <u>Salisbury Md</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Whom was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Bishop's Chapel</u>				DATE OF BURIAL <u>July 27, 1918</u>	
20 UNDERTAKER <u>H. H. Hough & Co</u>				ADDRESS <u>Salisbury Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

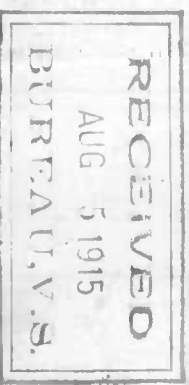
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Remotest wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH 12128
County Neonico

Village or City Stantich (No. 104) St. Ward

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Leonidas. D. Travers

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

⁶ DATE OF BIRTH Sept 01, 1915
(Month) (Day) (Year)

⁷ AGE 1 yrs. 10 mos. 27 ds. If LESS than 1 day, hrs. OR min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Maryland

PARENTS	¹⁰ NAME OF FATHER <u>Jesse R Travers</u>
	¹¹ BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
	¹² MAIDEN NAME OF MOTHER <u>Fannie Taylor</u>
	¹³ BIRTHPLACE OF MOTHER (State or country) <u>md.</u>

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse R Travers
(Address) Stantich Md

¹⁵ Filed July 28, 1915 Suzanne J. Walker
Deputy Secy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH July 28, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from July 18, 1915 to July 28, 1915
that I last saw him alive on July 28, 1915

and that death occurred on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute ileocolitis

(Duration) yrs. 24 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. K. Turner, M. D.
July 28, 1915 (Address) Stantich Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL Stantich Md DATE OF BURIAL July 29, 1915

²⁰ UNDERTAKER C. E. Messick ADDRESS Stantich Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

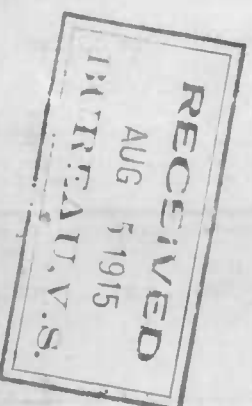
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 12129
County Wicomico

Village or City Penticoke (No. _____)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 337

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lewis Thomas Walter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH October 18, 1845
(Month) (Day) (Year)

7 AGE 69 yrs. 9 mos. 2 ds. If LESS than 1 day,.....hrs. OR.....min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Robert Walter
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Rosa Walter
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucy J. Walter
(Address) Penticoke Md.

15 Filed July 21, 1915 Lucy J. Walter
Deputy Social REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1915, to July 20, 1915, that I last saw him alive on July 20, 1915

and that death occurred on the date stated above, at 2:30 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. W. W., M. D.

July 21, 1915 (Address) Penticoke Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS; INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Travis P. Cemetery July 22, 1915

20 UNDERTAKER ADDRESS

C. E. Messink Bowie Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

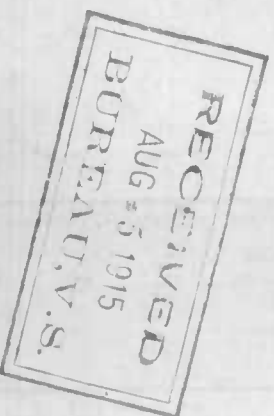
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scallie," etc.), "Prophy," "Exhaustion," "Heart failure," "Haemorrhage," "Idaniloid," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH 12130
County Wicomico
Village or City Near Hebron (No. _____) St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 338

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Vergil Watson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 1895 (Month) _____ (Day) _____ (Year) 1895

7 AGE 20 yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Iowa

10 NAME OF FATHER William Watson

11 BIRTHPLACE OF FATHER (State or country) Pitts ville

12 MAIDEN NAME OF MOTHER Grace White

13 BIRTHPLACE OF MOTHER (State or country) Iowa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minor Watson(Address) Hebron

15 Filed July 13, 1915 R. S. Phillips
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unavoidable accident
Struck by railway train
Fracture of Skull
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Conway, M. D.
July 13, 1915 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Manila Cemetery July 14, 1915
20 UNDERTAKER ADDRESS

E. E. Sebrage Manila Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 7 1915

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

12131

County AccomackSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 332Village or City Pittsville (No. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Anna West

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
(Write the word)

6 DATE OF BIRTH 3 17 1838
(Month) (Day) (Year)

7 AGE 77 yrs. 4 mos. 11 ds. OR 1 day, _____ hrs. _____ min. ?
If LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Delaware

PARENTS
10 NAME OF FATHER Wm. B. Ottwell
11 BIRTHPLACE OF FATHER (State or country) Delaware
12 MAIDEN NAME OF MOTHER Loreania Phillips
13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lillian Grey(Address) 2 Bullards Mt. Road

15 July 30, 1915 J. H. Haffner
Filed _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1915 to July 24th, 1915.
that I last saw him alive on July 21st, 1915.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Robert Allegood, M. D.
July 30, 1915 (Address) Delmar Del

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Line McEmery July 30, 1915
20 UNDERTAKER ADDRESS

H. O. Parsons Pittsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificate.

1 PLACE OF DEATH

County MillicomiesVillage or City Fruitland(No. 891)St. Trappe dist Ward 7STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Virgie White

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word)

6 DATE OF BIRTH

May 11, 1915
(Month) (Day) (Year)

7 AGE

1 yrs. 27 mos. 27 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE (State or country)

md.

PARENTS

10 NAME OF FATHER

Isaac White

11 BIRTHPLACE OF FATHER (State or country)

md.

12 MAIDEN NAME OF MOTHER

Edith Roberts

13 BIRTHPLACE OF MOTHER (State or country)

md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac White(Address) Loamie Foster

15

Filed July 6, 1915, V. S. Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 6, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

July 5, 1915, to July 6, 1915.that I last saw her alive on July 6, 1915.and that death occurred on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jos L. McLaughlin, M. D.July 6, 1915 (Address) Fruitland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Loamie Foster July 7, 1915

20 UNDERTAKER

ADDRESS

J. H. Stewart Salisbury, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms): *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal ecchymæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 15 1915
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5
County Wicomico

12138

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City Mar Fritland (No. Grapple best St. 7 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 30, 1915
(Month) (Day) (Year)

7 AGE Still Born It LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Mar Fritland Md

10 NAME OF FATHER John H. Williams

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Brunning

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Williams Father

(Address) Fritland Md

15 Filed July 31, 1915 N P Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Still Born 1915 to July 30, 1915, that I last saw him alive on July 30, 1915

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Still Born
no Physicians or
midwife

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory unknown
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) N P Turner Local Registrar, July 31, 1915 (Address) Balis Highway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Fritland Md DATE OF BURIAL July 31, 1915

20 UNDERTAKER Isaac H. Fashield ADDRESS Fritland Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 15 1915

BUREAU, V.S.

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1 PLACE OF DEATH
County Wicomico Salisbury Dist. 12134
Village or City Salisbury Md (No. 607, Wilson St.; 9 Ward) Registration Dist. No. 333
2 FULL NAME not named Wilson [if death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH July 12th, 1915
(Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 3 ds. If LESS than 1 day, 3 hrs. OR 1 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Salisbury Md

10 NAME OF FATHER Richard Vance

11 BIRTHPLACE OF FATHER (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Lilly Wilson

13 BIRTHPLACE OF MOTHER (State or country) Salisbury Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lilly Wilson

(Address) Salisbury Md

15 Filed July 24th, 1915 N.P. Turner

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 12th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I ~~attended deceased from~~
1915, to 1915,

that I last saw him alive on 1915

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Called at the home of Lilly Wilson July 24th 1915, and obtained the information contained in this certificate
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) N.P. Turner Local Registrar

July 24th, 1915 (Address) Salisbury Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

In the Back yard July 13th, 1915

20 UNDERTAKER Wasburris ADDRESS by Emma Fletcher Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 25 1915
BUREAU, V. S.